

THE ROLE OF PARENT TRAINING GROUPS IN THE TREATMENT OF ATTENTION-DEFICIT HYPERACTIVITY DISORDER

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Article:

Within the fields of child development and child clinical psychology, recognition is growing of the important role that families, in particular parents, play in the growth and development of children. Compared with a simplistic unidirectional view, researchers and clinicians increasingly have conceptualized parent-child influences from a more realistic transactional pattern^{14,15,62} or a systems perspective.⁴⁵ For example, developmental researchers such as Baumrind,¹² Maccoby and Martin,⁴² and Schaefer⁶³ have consistently found that healthy child development is most likely to occur in the context of high levels of parental warmth and acceptance, consistent behavioral control, and acceptance and encouragement of individuality and psychological autonomy. Consideration of parental influence is, however, important when development is disrupted in some way.

The role of family factors and parental influences has become increasingly apparent not only in understanding normative or typical developmental concepts but also in treatment approaches for children with behavioral or emotional problems. In the 1960s and 1970s, the growth of family therapy approaches raised the issue of treating children within the context of the family and of interpreting the child's symptoms in the context of the role the symptoms serve in the family's functioning.⁴⁵ In addition, clinicians and researchers began to question the efficacy of traditional individual child psychotherapy^{40,41} and became increasingly concerned with the issue of maintenance and generalization of treatment effects.⁵³ The successful implementation of behavioral approaches, which lend themselves to parent training models, also played a role in the growth of consideration of family variables. Finally, a large body of literature illustrates the link between family factors and the development of psychological problems in children (e.g., poor behavior management practices^{28,51,52}; parental psychopathologic abnormalities⁶¹). Not only are positive parent practices related to healthy child development¹² but maladaptive parenting practices are thought to be associated with clinical problems such as noncompliance, oppositionality, and aggression.²⁸

The role of the family also is apparent in the conceptualization and treatment of attention-deficit hyperactivity disorder (ADHD). ADHD is currently thought to be a developmental disorder of attention span, impulsivity, or overactivity as well as of rule-governed behavior,⁷ with biologic factors (e.g., neurologic and genetic) accounting for the onset of the disorder in most children with ADHD.² Some studies suggest that parents, in particular mothers, of children with ADHD may demonstrate less than effective parenting practices. For example, mothers of children with ADHD issue more commands and issue more negative statements.^{10,65} These negative mother-child interactions are, however, reduced when the children respond positively to stimulant medication.^{9,11,38} It appears that ADHD is not caused by poor parenting per se. Negative parent-child interactions are more likely a reaction to rather than a major cause of behavioral difficulties associated with ADHD.

Nevertheless, parents play an essential role in establishing and maintaining a "prosthetic social environment."⁵ First, many children with ADHD also have other behaviors such as disobedience, noncompliance, and aggression.⁵ These difficulties are thought to be learned behaviors that have developed through less than positive or ineffective parent-child interactions.⁶ For example, Patterson⁵¹ and others describe a pattern of

coercive interaction and *coercion escalation* in which the parent and child struggle for control. Other studies have shown that the exacerbation and continuation of ADHD symptoms and especially the maintenance of oppositional behavior in these children are related to parents' use of commands and criticism.^{19,20} Because these patterns are learned, it is thought that more adaptive parent influences can be developed through treatment, thus replacing these more negative and aversive techniques.

In addition, increasing evidence documents the stress experienced by parents of children with ADHD.³ This stress is related primarily to child characteristics such as aggression and the severity of the child's ADHD symptoms. Parental characteristics such as maternal psychopathologic abnormalities were found to play a role as well. Parenting stress, if not addressed in treatment, necessarily detracts from the parents' ability to participate actively in their child's treatment and in the coordination of care. Thus, the essential role of the child's social environment, in this case the influences of his or her parents, in the treatment of ADHD seems clear.

As Bronfenbrenner¹⁷ noted:

Whether parents can perform effectively in their child-rearing roles with the family depends upon the role demands, stresses, and support emanating from community settings. . . . The availability of supportive settings is, in turn, a function of their existence and frequency in a given culture or subculture.

This article reviews two ways in which clinicians can address the role demands and stress of parents of children with ADHD: parent training and parent support groups. The theoretical underpinnings of several of the most common parent training approaches, including the rationale, advantages, and empirical support, are discussed. Next, developmental and family factors that should be considered when choosing and implementing treatment are reviewed. Finally, the concept and benefits of parent support groups, as an adjunct to other treatment approaches, are discussed.

PARENT TRAINING APPROACHES

Working with parents as cotherapists has for some time been a recognized approach for the treatment of child behavioral and emotional difficulties. Even Freud,³⁰ in his treatment of Little Hans' phobic behaviors, did not treat Hans directly but instructed the child's father in techniques for resolving Hans' underlying conflicts and fears. An early example of this approach, filial therapy,³² has as its goal to teach parents techniques of individual play therapy to use at home to enhance the parent-child relationship. As early as 1959, Williams applied behavioral techniques to parent training in the management of children with tantrums.⁴⁷ In addition to therapeutic approaches using parent training, a number of parent education programs have been equally popular, including Parent Effectiveness Training by Thomas Gordon, among others.

The growing popularity of parent training stems from several factors. First, including parents as cotherapists increases the maintenance and generalizability of skills outside therapy session.⁴³ Second, increased costs of psychological services and decreasing insurance availability have made behavioral parent training approaches, especially in a group format, a cost-effective therapeutic option.⁴⁸ Third, including parents in the therapeutic process affords them an enhanced sense of personal and parental competence.^{23,64,71} The acceptability and social validity of this procedure are growing because the techniques are based on natural, observable behaviors.¹⁸ Finally, a large body of literature documents the important role of family factors in the development and maintenance of adaptive and maladaptive child behaviors. Given these advantages, it is no surprise that clinicians would begin to include parent training as one of many approaches for the treatment of children with ADHD.

Treatment Rationale

Parent training is an essential component in the treatment of ADHD. First, although stimulant medications do produce significant behavioral improvements for many children with ADHD, 20% to 30% of the school-aged

population and an even higher percentage of the preschool population may not show a favorable response.⁸ Even when a favorable response is obtained, a small percentage of children with ADHD may exhibit undesirable side effects, which may be of sufficient magnitude to rule out medication.

Even when children show a favorable medication response in the absence of significant side effects, this does not automatically provide parents with improved parenting skills. These skills are essential if the parents are to respond to medication-induced improvements in the child's behavior. Of additional concern is the fact that these improvements in child behavior generally are not maintained when medication is not being taken. Thus, it is more difficult for parents to manage children with ADHD during late afternoons and early evenings, when the therapeutic benefits of stimulant medication are diminishing. Similar management problems may arise during weekends and school vacations, which are often designated as drug-free holidays. Thus, parents must rely on techniques other than medication to handle their child's behavioral difficulties. Specialized child management skills, which may be learned during parent training, can be beneficial in these situations.

Independent of whether medications are clinically effective, many parents prefer not to use any medication to manage child behavior. Although it is a clinician's responsibility to inform parents of his or her professional opinion regarding the potential benefits of medication, ultimately it is the parents' decision to proceed or not with such a recommendation. When parents express a preference not to employ stimulant medication, other treatment approaches must be employed, albeit with the understanding that other methods are unlikely to normalize ADHD symptoms. In clinical situations like this, many parents are more comfortable addressing their child's ADHD difficulties through parent training strategies.

Additional justification for initiating parent training-counseling stems from the fact that children with ADHD frequently exhibit other psychosocial difficulties, such as aggression, oppositional-defiant behavior, conduct disturbance, academic underachievement, diminished self-esteem, depression, peer relationship problems, enuresis, and encopresis. Because many of these problems cannot be managed through stimulant medication therapy, they must be addressed by other means. For many children, parent training-counseling is often used for this purpose. The oppositional-defiant or noncompliant behavior of children with ADHD is an appropriate target for parent training-counseling. As noted by Patterson,⁵¹ noncompliant behavior is pervasive and can lead to more serious behavioral difficulties, such as repetitive lying, stealing, and other chronic violations of societal rules. In combination with ADHD, noncompliance is highly stable over development and is a significant predictor of later maladjustment during adolescence and young adulthood. Finally, because noncompliance is so pervasive, its successful management can lead to numerous improvements in overall psychosocial functioning.

The problems of children with ADHD clearly place a tremendous strain on family functioning. Traditional parenting techniques, which may work well with normal siblings, are often less effective with children with ADHD. Not only is the normal parenting process disrupted but often parent-child relations, sibling relations, marital relations, and parental personal functioning are affected as well. Parent training can address these difficulties as well as the stress and lack of self-confidence experienced by many of these parents.³

Parent training is particularly effective in enhancing classroom management techniques such as providing additional incentives for successful compliance in school. The information parents gain about ADHD within parent training is also instrumental in educating the child's teachers, who may be less informed about ADHD. Finally, informed parents can be more effective advocates on behalf of their child with ADHD.

Theoretical Considerations

Additional justification for parent training in the treatment of ADHD stems from a consideration of the following theoretical points. In recent years, important clinical and empirical evidence suggests that the behavior problems of children with ADHD stem more from an underlying motivational deficit or insensitivity to consequences than from a deficit in core attentional processes.⁸ Much of the impetus for conceptualizing ADHD as a neurologically based, motivational disorder comes from the observed variability in ADHD symptoms across situations; (2) the differential responses of children with ADHD to reinforcement and possibly

to punishment⁸; and (3) advances in theories of the components of attention that stress a greater role of motivational factors in sustained attention than in other components of attention.⁵⁹

Thus, ADHD is a condition whose behavioral symptoms vary as a function of the situational demands placed on the child. These situational demands include, among others, (1) the degree to which a child finds a situation interesting or boring; the degree to which the situation is novel or familiar; (3) the amount of structure imposed; (4) whether the child is in a one-on-one situation with an adult or in a group; (5) and the amount and type of feedback provided. Therefore, the behavior and performance of children with ADHD are highly sensitive to variations in situational demands and in the types of feedback and consequences they encounter. On the basis of such findings, Barkley⁸ and others concluded that the behavior problems of children with ADHD stem primarily from an underlying motivational deficit rather than from a deficit in core attentional processes.

This motivational deficit hypothesis suggests that parents must provide children with ADHD with ongoing external motivation to overcome their difficulties in situations that they do not find intrinsically interesting. One way this may be accomplished is through home-based applications of specialized contingency management techniques that may be learned through participation in the parent training portion of the treatment program.

OVERVIEW OF PARENT TRAINING APPROACHES

Parent training programs have been developed specifically for the remediation of oppositional or aggressive behaviors or both that have been applied to the treatment of children with ADHD. Three such approaches, Barkley's⁶ *Defiant Children*, Patterson and the Oregon Social Learning Center Approach to parent training^{50,52,54}; and Forehand and McMahon's approach,²⁸ *Helping the Noncompliant Child*, share many elements but also differ in the use of social reinforcement and contingency management, treatment formats (e.g., individual compared with group), and punishment procedures. For a review and comparison of these approaches, the reader is referred to the article by Newby et al.⁴⁷ In this article, we concentrate on one approach, that described in Barkley's⁶ *Defiant Children*, to illustrate the application of this approach to the treatment of ADHD. The original version of this program first appeared in the 1981 text, *Hyperactive Children: A Handbook for Diagnosis and Treatment*. A modified version was described in detail in the 1987 text, *Defiant Children: A Clinician's Manual for Parent Training*,⁶ as well as adaptations specifically for children with ADHD.⁸ This program is in many respects similar to the Forehand approach, because both programs were greatly influenced by Hanf's³³ two-stage behavioral program for child noncompliance.

Treatment Objectives

One of the program's most important goals is to increase parental knowledge and understanding of ADHD, primarily through didactic instruction. An equally important objective of the program is to provide parents with ongoing clinical supervision in the use of specialized contingency management techniques, which may be used to address the motivational deficits or noncompliant behavior displayed by children with ADHD. A third objective is to facilitate parental adjustment to having a child with ADHD, primarily through the use of cognitive therapy strategies. Cognitive therapy strategies may also be used to achieve a fourth goal, which involves increasing parental compliance with the prescribed treatment regimen. Finally, in the process of meeting the preceding objectives, it is the overall purpose of this treatment program to provide parents with coping skills, which lead to happier and less stressful lives, both for themselves and for their children with ADHD.

Specific Training Steps

The program generally can be completed within 8 to 12 sessions. Following is a discussion of the specific steps that make up the complete intervention program. Each step builds on the previous one, and in each case, parents are provided with homework assignments and detailed summary sheets to increase skills acquisition and generalization of techniques learned in the parent group.

Step 1: Program Orientation and Review of ADHD

The overall objectives of this step are (1) to acquaint parents with the mechanics of conducting the treatment program, (2) to begin increasing their knowledge of ADHD, and (3) to begin addressing any faulty perceptions that they may have about themselves or about their children. Following a general overview of the program, the therapist begins discussing the topic of ADHD by reviewing its history, its numerous label changes, its core symptoms, the currently accepted clinical criteria used to formulate its diagnosis, and its prevalence rates in both clinic and general populations. Also covered are many of the commonly encountered associated features of ADHD, such as oppositional-defiant behavior, aggressiveness, academic underachievement, social skills deficits, emotional immaturity, and atypical physical or medical characteristics, all of which set these children apart from other children in the general population. Currently available information about adolescent and adult outcomes is presented as well. Finally, a brief review of available treatment approaches is given, with emphasis placed on the need for utilizing a multidimensional clinical management approach. Also emphasized during this review of treatment procedures is the notion that ADHD is, in many cases, a lifelong condition that is coped with or compensated for rather than ultimately cured.

Step 2: Understanding Parent-Child Relations and Principles of Behavior Management

The objectives of this step are twofold: to provide parents with a four-factor model for understanding deviant child behavior and to increase parental knowledge of behavior management principles as they apply to children with ADHD. After reviewing carry-over concerns from the previous session, parents are provided with a conceptual framework for understanding deviant parent-child interactions and their therapeutic management. Initially, the theoretical views of Bell and Harper¹⁵ and Patterson⁵⁰ are introduced in general terms. In this context, parents are alerted to four major factors, which, in various combinations, can contribute to the emergence or maintenance or both of children's behavioral difficulties: child characteristics, parent characteristics, situational consequences, and familial stressors. Thus, parents are told that, whereas inborn characteristics and stressors may increase the risk of behavioral difficulties, it is the nature of the parent-child interactions that most reliably affect child behavior. Hence, the rationale for parent training is provided, that is, the need to modify the way parents respond to their children's behavior. Parents also are provided with an overview of general behavior management principles as a way of preparing them for later coverage of specific behavioral techniques. This overview may be introduced with a discussion of how antecedent events as well as consequences can be altered to modify children's behavior. Included in this discussion is a review of the various situational variables and feedback conditions that can affect their behavior and performance.

Step 3: Enhancing Parental Attending Skills

The therapeutic intent of this step is to begin teaching parents positive attending and ignoring skills in the context of the special time exercise. Because many children with ADHD engage in fewer behaviors that elicit any type of positive parental response, the greater percentage of parent-child interactions are likely to be corrective, directive, and involve coercive patterns.⁵⁰ Therefore, procedures designed to improve both the amount and quality of parental attention to the child are reviewed. This is accomplished by teaching parents the techniques of special time. Unlike other types of special time that simply involve setting aside time with the child, special time in this program requires that parents must remain as nondirective and as noncorrective as possible. The child is allowed to select an activity to be used daily and the parent is to interact with the child only and is not to give commands or ask questions. The use of parental social reinforcement is emphasized as is the fact that further behavior management techniques lose their effectiveness if there is not a positive parent-child relationship as a base.

Step 4: Paying Positive Attention to Appropriate Independent Play and Compliance: Giving Commands More Effectively

This step involves three new objectives: (1) to extend positive attending skills to appropriate independent play, (2) to extend positive attending skills to child compliance with simple parental requests, and (3) to teach parents more effective methods of communicating commands. Parents are now taught to become skillful at "catching" their children in instances of appropriate behavior, especially those that have proved problematic in the past.

Likewise, positive attending skills are encouraged in the context of the child complying with parental commands as well as with spontaneous instances of prosocial behavior or compliance with house rules.

The final topic of discussion for this step in the training program is the manner in which commands are given. Parents are encouraged to only issue commands that they intend to follow through on. They are taught that commands should take the form of direct statements rather than questions; that commands should be relatively simple; that they should be issued in the absence of outside distractions; that they should be issued only when direct eye contact is being made with the child so as to increase the likelihood of the child attending to such instructions; and that the child should repeat the commands back to parents to give them an opportunity to clarify any misunderstanding before the child responds.

Step 5: Establishing a Home Token System

The establishment of a reward-oriented home token system is the major focus of this step. Such a system serves to provide children with ADHD with the external motivation they need to complete parent-requested activities that may be of little intrinsic interest. This system is designed to augment parental attention to appropriate and compliant child behavior while introducing highly predictable, frequent, and immediate consequences for specific behavior. Such a system is also utilized for the simple reason that positive attending and social praise from parents is often insufficient in the overall management of children with ADHD. Details of the token system are presented by Barkley.^{5,6} For 9- to 11-year-old children, points are used in place of chips and are monitored in a checkbook register or some other type of notebook of interest to the youngster. During the initial phase, children are allowed only to earn tokens, and parents are encouraged to dispense bonus tokens for especially well done chores or for appropriate behavior.

Step 6: Review of Home Token System—Using Response Cost

The therapeutic goal of this step primarily involves refinement of the home token system, which includes the addition of response-cost strategies for minor noncompliance. The initial part of this session is devoted to a review of the parents' efforts to implement the system, and suggestions are made for increasing the effectiveness of this system.

Until this point, parents are not given specific instructions regarding punishment tactics for noncompliance or other forms of misbehavior. This is done to ensure that positive interaction skills are well established. Also, the effects of punishment procedures are likely to be weak or short-lived without a high rate of positive attention for prosocial behaviors. This session introduces response cost. Response cost involves the removal of tokens or points. Parents are instructed to begin deducting tokens or points for noncompliance with one or two particularly troublesome requests or violations of household rules. The number of chips or points lost is equal to the number of chips or points that would have been gained had compliance occurred. For many children with ADHD, who over the past week had learned how to expend minimal effort to get the privileges that they desire, adding a response-cost component to their token system often increases their overall level of compliance with parental requests.

Step 7: Using Time-Out from Reinforcement

Time-out strategies for dealing with more serious forms of child noncompliance are the focus of this treatment step. After reviewing the home token system, the notion of using time-out from reinforcement, or simply, time-out, is introduced. Although most types of noncompliance are addressed through response cost, parents are encouraged to identify one or two especially resistant types of noncompliance, which potentially might become the targets of time-out. Once these are identified, attention is focused on the mechanics of implementing the time-out procedure. Previous assumptions about and implementation of time-out are discussed and clarified by cognitive restructuring techniques. Failure to do so runs the risk that parents will not be properly motivated to incorporate this treatment strategy in the manner in which it is intended. A considerable amount of time is spent detailing the mechanics of time-out before its implementation at home. Details such as the amount of time a child should spend in time-out, appropriate locations, and conditions that must be met to leave time-out are discussed.

Step 8: Extending Time-Out to Other Misbehavior and Managing Children's Behavior In Public Places

The goals of this step are to begin extending parental use of time-out to other problem areas and, more generally, to begin expanding use of the entire home-based program to settings outside the home. Much of the session is used to review parental efforts to incorporate the response-cost and time-out strategies into the ongoing home token system. Provided that implementation of these procedures has proceeded without major problems, parents are instructed to use time-out for two or three other types of misbehaviors (e.g., fighting with siblings, swearing). The use of time-out is restricted initially to the home setting, and parents are encouraged not to attempt to implement such procedures outside of the home until success is achieved at home.

Assuming that parents have demonstrated comfort and competence with the previous techniques, disciplining procedures are extended to experiences with the child in public places. Most children with ADHD present problems for their parents in public places, such as stores, churches, restaurants, or in the homes of others. All of the principles previously taught are presented in the context of managing public misbehavior and noncompliance. Parents are encouraged to (1) anticipate when and where problems are likely to occur and (2) to establish a clear plan for dealing with these difficulties before entering a predictably problematic public situation. This plan includes reviewing with the child their expectations for his or her behavior in this setting; establishing some incentive for compliance with these rules; and specifying what types of punishment will be applied, should noncompliance with these rules ensue. Of equal importance to the success of this plan is to have the child state his or her understanding of these rules and consequences before entering the public situation.

Step 9: Handling Future Behavior Problems

A final session is used to review the essential principles of management that were incorporated into each of the methods parents were taught to use. Examples of anticipated or hypothetical problems may be generated by the therapist and parents. Techniques for addressing the problem are then reviewed. Parents are reminded about the chronicity of ADHD and that some degree of long-term adherence to the program is necessary to maintain appropriate behavior. It is customary to schedule a "booster" session 4 to 6 weeks after the final session to provide further support to parents in continuing to manage the child.

Following the child-management training portion of the program, other issues may be added to deal with the particular problems of parenting children with ADHD. Common among these include getting homework completed, addressing academic and achievement issues, and handling problematic peer relations.

Benefits

As might be expected, parental knowledge and understanding of ADHD generally increase significantly following parent training-counseling as does parental expertise in using specialized child management skills to address the motivational deficits and the noncompliant behavior of children with ADHD.³ Newly acquired parenting skills can also facilitate the behavioral management of other problem areas, such as enuresis or encopresis, which often accompany ADHD.

A number of indirect family benefits may also occur.³ For example, many parents report significant improvements in the behavior of siblings. In some cases, they may also report reduced personal and family stress. Marital tensions stemming from child management issues frequently are lessened. Many parents begin to view themselves more positively in their parenting roles, which over time can enhance parenting self-esteem. Likewise, because children with ADHD encounter more frequent positive reinforcement from their parents, they too may feel happier and more confident. In addition to feeling better about themselves, many parents and children also begin to like one another even more so than before. Overall family functioning may become less stressful, with siblings and children with ADHD generally interacting more cooperatively. On a less frequent basis, improvements in a child's home behavior may be accompanied by improvements in school behavior and academic performance. To the extent that daily report cards and other classroom management strategies are employed directly, additional improvements in school functioning may occur as well.

Although such benefits are impressive, additional empirical support must be established specifically for children with ADHD. Research on groups of children with aggressive and noncompliant behaviors does, however, document such changes as a result of parent training.^{28,50} Thus, it is expected that future investigations will identify similar results with children with ADHD.

SELECTION CRITERIA

Various factors should be considered when referring a particular child and family to parent training. Developmental characteristics of the child as well as family factors must be taken into account as part of the clinical decision-making process.

Child Characteristics

One of the simplest criteria to assess is the chronologic age of the child. Most of the available parenting programs^{6,28,50} are designed for use with children between 3 and 11 years of age. Modifications of this program for older and younger children are discussed later in the article. These age guidelines, of course, presume a relatively close correspondence between a child's chronologic age and mental age. If a significant discrepancy exists, it can affect the referral process, and the child's mental age should be considered.

In addition to chronologic and mental age considerations, the child's diagnostic status must be taken into account. Although a diagnosis of ADHD is a necessary condition for referral, it is by no means sufficient on its own. The severity of the ADHD diagnosis also comes into play, as does the presence and severity of co-occurring conditions. In general, parent training is ideally suited to meeting the clinical management needs of children with ADHD who also display significant oppositional-defiant behavior or conduct problems. Even when these associated behavioral complications are absent, parent training may still be beneficial to children whose ADHD is moderate to severe in intensity. In cases in which the ADHD may be extremely severe, however, it may be necessary to consider other interventions first, such as placing the child on trial treatment with stimulant medication or in a residential setting if the child demonstrates extreme aggressiveness and violence. In addition, if the child also experiences significant depression, anxiety, or other emotional difficulties, the emotional complications are independent of the ADHD and clearly of greater clinical concern, and often must be addressed first. Once such difficulties are resolved, however, it may then be appropriate to initiate parent training-counseling services.

For those children with mild ADHD who do not exhibit oppositional-defiant behavior or related problems, implementation of the complete treatment program may not be the most efficient means of meeting their clinical management needs. Nevertheless, their psychosocial circumstances may still be enhanced either by the parent counseling portion of the program or by parental acquisition of select contingency management skills (e.g., home token system) that address their motivational deficits.

Specific Developmental Adaptations

As mentioned previously, most of the parent training programs have been applied to parents of children in early and middle childhood. Although the reasons for the behavioral difficulties and the techniques apply to other age groups, adaptations are needed when one is working with families with preschoolers or adolescents with ADHD. Heinicke and Strassmann³⁴ point out that it is not sufficient to ask whether a treatment is effective. One needs to consider the effectiveness of specific treatment approaches for particular problems for children of a certain age. In treating preschoolers and adolescents with ADHD, therefore, some adaptations to the program are necessary to maximize the benefits.

Adaptations for Preschoolers

Several adaptations are needed when using parent training programs with parents of preschoolers. Most of the available programs have been developed for use with parents of preschoolers who demonstrate oppositional or aggressive behaviors or both as opposed to ADHD specifically. It is possible, however, to adapt ADHD parent training programs to younger children or expand current parent training programs with preschoolers to include ADHD.^{1,36,39}

Eyberg,²⁵ Kazdin,³⁹ and others have found that the most successful programs go beyond strict operant training in reinforcement contingencies to include general ways of interacting positively and sensitively with the child.^{26,66} The previously described program by Barkley addresses this in the initial sessions that focus on "special time" and positive attending behaviors. Eyberg and Robinson²⁶ emphasized that strengthening the parent-child relationship leads to broader and more long-term effects on family functioning. Their program includes training in typical child management skills including contingent and consistent praise and time-out. The relationship-enhancing portion includes teaching parents active listening skills, the ability to follow the child's lead in nondirective play, and the provision of emotional support. Their program resulted in behavioral improvements on parent report and observational measures. Moreover, skills had generalized to untreated siblings, thus affecting the larger family environment.

The most obvious adaptation in most parent training programs needed for preschoolers is in the use of token economy systems; points are obviously inappropriate because the young child does not have the number skills to understand the program. More concrete rewards (stickers, poker chips) are needed, and the time from behavior to reward or punishment must be short. Although all children with ADHD require frequent feedback, it is even more apparent with the young child with ADHD. It may be difficult for the preschooler to wait until the end of the day to "cash in" his or her stickers, so more immediate and naturally occurring contingencies can be used (e.g., Before you can go outside, you must pick up your toys). Picture prompts rather than written guides may be used to identify target behaviors and rewards (e.g., picture of shoes for getting dressed, picture of tricycle for bike riding). The number of target behaviors may need to be reduced as well, and, at any age, these goals need to be examined within a developmental context (e.g., the preschooler's development of autonomy). Another potential problem may arise with the concept of "cashing in" poker chips or stickers for rewards. If the chips are actually turned in, some preschoolers may confuse this with the concept of response cost for misbehavior. For these children, the use of naturally occurring punishments (e.g., losing a turn at a game for cheating) or time-out may be more effective.

Adaptations for Adolescents

Adolescents are faced with unique developmental tasks. These include individuating from parents; developing a self-identity; adjusting to sexual maturation; and developing peer relationships. ADHD and co-occurring behavioral difficulties can interfere with the accomplishment of these goals. Although parent training is an important part of a multidimensional treatment plan for teens, adaptations are needed. Programmatic guidelines for parent-mediated interventions in older children and adolescents are described in the *Parents and Adolescents Living Together* series by Patterson and Forgatch⁵⁴ and Forgatch and Patterson.²⁹ In their approach, the program is augmented with additional sessions that present techniques for improving family communication and negotiation skills.

Another extension of parent training that is particularly successful with adolescents with ADHD is the behavioral- family systems approach developed by Robin and Foster.⁶⁰ In addition to medication, school interventions (e.g., behavioral study skills training, special education), parent education about ADHD, and behavioral training, this approach incorporates problem-solving-communication training. Because conflicts over rules and regulations represent the most common home problem between the adolescent with ADHD and parents, assisting the parents in achieving more effective, democratic conflict resolution skills⁶⁰ can reduce the behavioral difficulties and at the same time foster responsible adolescent individuation.²¹ Families are taught a four-step model of problem solving that includes defining the problem; generating alternative solutions; evaluating the ideas and choosing the best one; and planning to implement the selected solution.

Parent Characteristics

Referral to parent training is, of course, not just a function of the child's characteristics. Numerous parent characteristics enter into the clinical decision-making process as well. Perhaps the most important of these is the parent's ability to tolerate the child's deviant behavior. Whereas some parents can cope satisfactorily with even

the most severe child behavior problems, others are highly distressed by much milder child difficulties, For this reason, referral for parent training-counseling depends heavily on their perceived need for such services.

Another basis for referral arises when parental differences of opinion exist with respect to child management issues. For example, mothers and fathers may differ significantly in their interpretations of their child's ADHD, or they may seriously disagree over how to manage his or her behavior. Joint participation in the treatment program affords them an opportunity for acquiring a common base of knowledge about ADHD, from which they may also employ more consistent child management strategies.

In situations in which marital tensions stem from areas other than child management issues, referral to the program may not be appropriate at first. Some parents may be so preoccupied with their troubled marital circumstances that they are unable to commit the time and energy necessary for meeting the increased parenting responsibilities required by the treatment program. Or, as sometimes happens, parents are so unwilling to compromise with one another that they are unlikely to agree on using recommended parent training strategies. When such serious complications exist, parents should be referred for marriage counseling, either before or concurrent with their participation in the parent training-counseling program.

Other characteristics such as parental psychiatric difficulties may necessarily divert parental attention from routine parenting responsibilities. Coping with personal distress such as depression or anxiety may make it difficult to put forth the effort necessary to benefit from participation in the parent training-counseling program. For this reason, it is often necessary to direct the parents to appropriate medical or mental health professionals or both to begin addressing their concerns. Such assistance can occur either before or during participation in parent training-counseling. In addition, the parents may best be served in an individual rather than group parent-training format.

Finally, parental perceptions of themselves, of their children, and of the ADHD diagnosis itself can be highly inaccurate at times. Such inaccuracies are frequently accompanied by negative feelings, such as guilt, diminished self-esteem, sadness, and hopelessness. When these emotional complications arise, they can seriously interfere with the normal parenting process and with parental efforts to acquire specialized child management skills through participation in the parent training program. For these reasons, additional parent counseling may be needed. Cognitive and cognitive-behavioral interventions may be particularly helpful in these instances.¹³

Family Factors

In addition to personal and marital issues, parents of children with ADHD may face external stresses and strains not readily under their control. These might include, for example, sudden financial strains resulting from a recent job loss or ongoing stresses pertaining to the daily care of a chronically ill relative. Although such complications may not require ongoing professional assistance, they may affect the timing of the parents' decision to become involved in the treatment program. Consideration of the number of outside agencies (e.g., other mental health services) with which the family is involved and a discussion with the family about collaborative goal setting⁴ would be appropriate to ensure that the treatment priorities of the family are clear.

EMPIRICAL SUPPORT

Within the child clinical research literature are direct and indirect sources of empirical evidence of the effectiveness of parent training for the treatment of children with ADHD. Direct evidence comes from investigations that have evaluated the efficacy of parent training specifically within ADHD groups. The indirect evidence may be found in studies that employed somewhat different parent training approaches, either with children with ADHD or, more often, with children manifesting other types of behavior disorders.

Parent training-counseling interventions have not been researched extensively within groups of children with ADHD. In contrast with the hundreds of studies that have been published on the use of stimulant medication therapy, no more than 10 parent training-counseling investigations with children with ADHD specifically have

been reported. Among these, only two were conducted in a manner consistent with the parent training-counseling procedures outlined in the earlier texts.^{5,6} In both studies, however, child behavior improved significantly following parental participation in the treatment program.^{56,58} In the other published reports, similar behavioral parent training programs were investigated, but in none of these was parent counseling systematically incorporated into the treatment regimen.^{16,22,27,31,35,37,55} Despite this major procedural difference, these related investigations generally were consistent in demonstrating that parent training can bring about significant improvements in child behavior. Although additional research is needed to determine clinical guidelines for determining which children with ADHD and their families are best suited to receive parent training, these results suggest that behavioral parent training, either alone or in combination with parent counseling, can be therapeutically beneficial to children with ADHD and their families.

Studies on the effectiveness of parent training approaches with noncompliant, oppositional-defiant, and conduct-disordered children^{28,44} provide additional indirect support. In a series of related investigations, Forehand and associates demonstrated repeatedly that their behavioral parent training program is highly effective in bringing about significant improvements in targeted noncompliant and defiant behaviors⁴³ and in nontargeted behaviors such as aggression.⁶⁹ These treatment gains generalized readily from the clinic setting to the home environment⁶⁶ and typically remained stable over time, often up to 4 years following termination of treatments.²⁸ Modifications to the basic Forehand program (e.g., knowledge of social learning principles; targeting family functioning such as parental perceptions of child behavior, marital adjustment, and parental personal adjustment) enhanced the generalization or maintenance of treatment gains or both. Whereas final judgment on the overall therapeutic effectiveness of training-counseling for parents of children with ADHD may be deferred until further direct research is completed, a sufficient amount of preliminary support exists for conducting such interventions. Additional systematic and methodologically sound research must still be conducted to understand more completely the full impact of this treatment approach.

PARENT SUPPORT GROUPS

In addition to the benefits of parent training in the treatment of children with ADHD, many parents find the support and resources available from parent support groups helpful. The growth of parent support groups in the last 30 years reflects the self-help movement that emerged in the late 1960s and early 1970s.⁶⁷ These groups illustrate a larger movement in family support initiatives in which the aim is to enhance parent empowerment and to enable families to help themselves and their children. Weissbourd and Kagan⁶⁸ state that the purpose of family support programs is to "provide services to families that empower and strengthen adults in their roles as parents, nurturers, and providers." Regardless of the definition of family support, agreement is increasing regarding the key elements of programs and approaches that support rather than supplant the role of the family in children with special needs.⁶⁷ Included among these key elements are "practices that create opportunities for families to become more capable and competent with respect to their abilities to build and mobilize informal and formal network support systems that are responsive to their needs."²⁴ Parent support groups are one way to meet these needs. Although professionally led groups, such as parent training groups, provide support as well as training, the support that another parent offers is unique. For example, Yoak and Chesler⁷⁰ noted that parent-led groups are more likely than professionally led groups to develop a system of one-to-one parent contact, to work for changes in the system, and to organize opportunities for socializing. Both types of support are needed. Some parent support groups focus on specific disabilities and concerns, such as the Candlelighters, a group for parents of children with cancer. Others are broader based and cross specific disabilities or concerns, such as the parent advocacy and support group based in Massachusetts, the Federation for Children with Special Needs. Regardless of the focus, parent groups can serve many functions from providing mutual support for parents managing their children's conditions to advocating for service to offering relief from isolation.⁵⁷

In her book on organizing and maintaining support groups, Nathanson⁴⁶ outlined three important functions of parent-to-parent support. The first is *mutual support and friendship*. Parent support groups facilitate important social networks and provide an opportunity for parents to listen and share in a nonjudgmental atmosphere that can lessen the isolation and frustration that many parents experience. The second role is that of information gathering and sharing. Information and ideas range from identifying babysitters to loaning books and videos on

treatment and diagnostic approaches, Members of a formal group can have access to professionals in the community by inviting them as speakers at a meeting. Finally, parent groups can improve the system of care. Advocacy activities such as educating the larger public to the needs of children, fund raising, or lobbying legislators can impact on services for children in a powerful way.

The increase in parent support groups is reflected in the area of ADHD as well. In the 1980s, parent support associations for families of children with ADHD had grown to over 200 organizations throughout the United States alone. By 1989, the individual associations had organized into national networks and political action organizations such as Children with ADDH (CHADD) and Attention Deficit Disorders Association (ADDA) in the United States and the Foundation for Attention Disorders in Canada (see Appendix for contact information). These organizations as well as regional and local chapters and associations provide support and information to families. These groups have also been particularly active in educating the public about ADHD and in advocating for services. For example, CHADD President Sandra Thomas and Vice-President for Government Affairs, Mary Fowler testified before the House of Representatives on May 14, 1991, to urge Congress to include ADHD in educational services under Public Law 94-142. Because of their efforts and those of others, children with ADHD are eligible for services under the "Other Health Impaired" category and if they satisfy the criteria applicable to other disability categories (e.g., specific learning disability or seriously emotionally disturbed categories). In addition, the joint efforts of parents' organizations and professionals have resulted in the authorization and appropriation of funds for ADHD centers to synthesize and disseminate current knowledge related to ADHD.

In a comprehensive treatment plan for a child with ADHD, referral information for the parents about parent support groups is important and helpful. Information about professionally led groups, such as parent training, and parent-to-parent support groups is needed. As Oster⁴⁹ notes,

What parents offer other parents, through literature and friendship and organized peer support, is respect—with empathy—and without the burden of clinical assessment—a previous resource for families. . . . Ideally, the survival skills that only parents know are added to the rich expertise of professionals, who cure and teach and understand in a different way.

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APPENDIX

Parent Support Associations for Attention-Deficit Hyperactivity Disorder

Many parent support associations for ADHD now exist throughout the United States and Canada. The largest national association is Children with Attention Deficit Disorders (CHADD), which now has over 100 such support associations affiliated with it from almost every state in the United States. Another national organization is Attention Deficit Disorders Association (ADDA). For information on the nearest association, contact the following national headquarters.

CHADD

National Headquarters

Suite 185

1859 North Pine Island Road Plantation, FL 33322

(305) 384-6869

ADDA

4300 West Park Boulevard Plano, TX 75093

(817) 261-1490